

# San Bernardino County IHSS Advisory Committee Membership Application

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_, CA ZIP CODE: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_, CA ZIP CODE: \_\_\_\_\_

PHONE #: (\_\_\_\_\_) \_\_\_\_\_ MESSAGE PHONE: (\_\_\_\_\_) \_\_\_\_\_

EMAIL: \_\_\_\_\_

## GENDER:

☐ Female

☐ Male

## THE LANGUAGES YOU SPEAK, READ AND/OR WRITE:

*Check all that apply.*

☐ English

☐ Spanish

☐ Sign Language

☐ Other

Ethnicity: \_\_\_\_\_

Age Group (*Please check one*) ..... ☐ 18 – 59 ☐ I am age 60 and above

## Employment Status

(*Please check one below*) ..... ☐ Employed ☐ Retired ☐ Volunteer

Availability: ..... ☐ Mornings ☐ Evenings ☐ Afternoon

Are you a current or pass recipient of IHSS? ..... ☐ Yes ☐ No

Are you a parent of a minor who receives IHSS? ..... ☐ Yes ☐ No

Reasons why I am interested in being a member of the Advisory Committee:

\_\_\_\_\_

\_\_\_\_\_

Mail Completed Applications to: **San Bernardino County IHSS Public Authority**  
**600 North Arrowhead Avenue, Suite #100**  
**San Bernardino, CA 92415-0640**